MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Work Out Work Hardening 4110 Cedar Lake Dr. Bldg B, #201-202 Dallas TX 75227	MDR Tracking No.: M4-03-7316-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Liberty Mutual Fire Ins. 2875 Browns Bridge Rd. Gainesville GA 30504	Date of Injury: Employer's Name: United Parcel Service, Inc. Insurance Carrier's No.: 949628729

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/4/02	7/18/02	97546	$51.20	$0.00
7/16/02	7/16/02	99499-RP	$50.00	$0.00
7/23/02	7/23/02	99203	$74.00	$0.00
8/23/02	8/23/02	99212	$50.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

5/20/03: "This letter is requesting your help in receiving full compensation for services…remaining hours D.O.S. 6/4/02, 7/18/02….Social Service D.O.S. –7/16/02, 2nd OT Assessment / PT Eval.- DOS 7/23/02, Est Outpt Prob Foe H&E D.O.S. – 8/23/02…In summary, please review all documents of procedure closely."

PART IV: RESPONDENT'S POSITION SUMMARY

5/27/03: Response to MDR: "No 'Requests for Reconsideration' were received for any of these DOS. 6/4 and 7/18 units have been corrected. Reports and office visit not necessary as they are included in billing for work hardening. MAR for 99212 is $32.00."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT 97546 for DOS 6/4/02 and 7/18/02 were reimbursed on 6/24/03, therefore a dispute no longer exists.

CPT 99213 for DOS 8/23/02 was paid according to MFG, MAR, therefore additional reimbursement can not recommended.

CPT 99499-RP for DOS 7/16/02 was denied with 'G – This procedure is incidental to the primary procedure, and does not warrant separate reimbursement.' The report billed on this DOS was labeled "Case Management Note." According to MFG/MGR (II)(E) (1-10), this report is not required as a separate unit in addition to the work hardening criteria. Reimbursement can not be recommended.

CPT 99203, office visit for DOS 7/23/02 was denied with a 'G- This procedure is incidental to the primary procedure, and does not warrant separate reimbursement.' According to MFG/MGR (II)(E) (1-10), this office visit is not required in addition to the work hardening criteria. Reimbursement can not be recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Carol Lawrence	03/23/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____